House
REPUBLICAN
Conference

FloorPrep

Legislative Digest

Friday, July 24, 1998

John Boehner
Chairman
8th District, Ohio

House Meets at 9:00 a.m. for Legislative Business

***Anticipated Floor Action*:**
H.R. 4250—Patient Protection Act

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H.R. 4250—Patient Protection Act

Floor Situation: The House will consider H.R. 4250 as its first order of business today. Yesterday, the Rules Committee granted a modified closed rule providing for one hour of general debate, equally divided between Mr. Hastert and an opponent. The rule self-executes (i.e., incorporates into the base text of the bill upon passage of the rule) a manager's amendment to make several changes to the bill. It makes in order one amendment in the nature of a substitute by Mr. Dingell, debatable for one hour equally divided between a proponent and an opponent. Finally, the rule provides for one motion to recommit, with or without instructions.

Summary: H.R. 4250 amends current law to define the rights of patients and set nationwide standards for health insurance, specifically those regarding Health Maintenance Organizations (HMOs). In response to the growing concern that many in the public have expressed over the managed care industry, the measure is designed to ensure that the nation's health care system is accessible, affordable, and accountable. Specifically, the measure:

* lifts "gag rules" placed on medical providers to allow open communications between patients and doctors in order for the patient to make fully-informed decisions about the best course of treatment—a patient's "right to know." H.R. 4250 stipulates that group health plans may not impose any prohibition or restriction on physicians when communicating with patients. The substitute prohibits health plans from restricting physicians from giving advice to a patient about his or her health status, or the medical care or treatment for the condition or disease of that patient;

* guarantees access to emergency care by applying "prudent layperson" standards of what constitutes an "emergency" and prohibits health plans from arbitrarily refusing

to pay for covered emergency benefits. The measure also prohibits health plans from requiring patients or their doctors to get prior approval before seeking or providing emergency services;

* guarantees direct access for OB/GYN care to allow women the opportunity to bypass the insurance company's authorization process and go directly to their provider;

* guarantees direct access to pediatricians so that families can bypass the health plan's authorization process and make the plan's pediatrician the child's primary care physician;

* establishes new procedures and access to courts for grievances arising under group health plans;

* requires health plans to disclose information so that patients are able to learn what their health plan specifically covers, including benefits, doctors, and facilities, in addition to information on premiums and claims procedures. Such information must be made available upon request—with complete descriptions and in summary form (health plans may post this information via the Internet);

* requires insurance companies to provide patients access to immediate decisions from doctors about what is covered for emergency, urgent, and routine services;

* stipulates that an independent doctor must decide if a requested service is medically necessary, if originally turned down by internal review;

* establishes a procedure for certifying association health plans (AHPs), in which workers in small businesses and individuals who are self-employed pool together to allow such workers to obtain the economies of scale, purchasing clout, and administrative efficiencies enjoyed by employees of larger firms;

* guarantees patient choice of doctors by requiring health plans to offer point-of-service options, which allow participants to receive care from providers outside of their network for a higher premium and/or coinsurance payment;

* expands medical savings accounts (MSAs) to increase access to health care services and greater patient-control of health care expenditures. H.R. 4250 (1) allows both employers and employees to make contributions to MSAs; (2) lifts the small employer restriction; and (3) makes MSAs a permanent health care choice under the law. The bill includes six revenue offsets to cover the cost of these MSA expansions;

* creates "HealthMarts"—private, voluntary, and competitive health insurance "supermarkets" that transfer choice within the current employer-based health insurance market from small employers to their employees and dependents. HealthMarts will be established and run by private sector partnerships consisting of providers, consumers, small employers, and insurers;

* creates community health organizations (CHOs) to promote expansion of health coverage to all patients within their communities. Currently existing community health centers (CHCs) provide primary and preventive care for low-income individuals and the uninsured for roughly $300 per patient annually;

* reforms the guidelines governing health care lawsuits by (1) limiting "non-economic damages" to $250,000 but gives states authority to enact higher or lower limits if desired; (2) stipulating that juries may be informed about multiple recoveries paid to plaintiffs; (3) permitting periodic payment of damages, rather than immediate payment; (4) stipulating that lawsuits must be filed within two years of the date of discovery and no later than five years from the date of inquiry; (5) prohibiting plaintiffs from recovering 100 percent of damages from one party where multiple parties are involved; and (6) stipulating that punitive damages may not be awarded unless there is "clear and convincing evidence" of reckless disregard for victim; and

* safeguards medical record confidentiality to protect personal and sensitive health care data from abuse by requiring providers, plans, and employers to develop safeguards. H.R. 4250 also allows patients to access their medical records in order to view, copy, and amend them, and requires providers, plans, and employers to disclose their confidentiality policies to their patient, enrollees, and employees.

As stated above, the rule self-executes a manager's amendment into the base text of the bill. Specifically, the amendment: (1) expresses the sense of the House that patients are best served when they are empowered to make informed choices about their own health care and insurance, and a system that gives people the power to choose the coverage that best meets their needs, combined with insurance market reforms, offers great promise of increased choices and greater access to health insurance for all Americans; (2) adds six revenue offsets to cover the revenue cost of the bill's expansion of MSAs; (3) requires the offsetting of Social Security benefits to recover Supplemental Security Income (SSI) overpayments; (4) prohibits health care providers and plans from selling protected health information as part of conducting health care operations; (5) raises the amount of penalties that may be imposed on group health plans from $250 a day to $500 a day; and the total penalties from $100,000 to $250,000; and (6) makes several technical and conforming corrections to the bill.

Views: The Republican leadership supports passage of H.R. 4250. An official Clinton Administration position was unavailable at press time.

Amendments: As stated above, the rule makes in order the following substitute amendment, debatable for one hour:

— Dingell Substitute —

Mr. Dingell will offer an amendment in the nature of a substitute to create a set of federal standards designed to protect access to care, ensure quality care, and provide health plan accountability. The amendment contains the language of H.R. 3605, the Patients' Bill of Rights Act.

Access to Care

The substitute allows a limited point of service option (POS) for employees who are offered only a "closed network" Health Maintenance Organization (HMO). It requires the health plan, not the employer, to make the POS option available. The substitute requires plans to have a sufficient number, distribution, and variety of providers to ensure that all enrollees receive covered services in a timely manner. It allows doctors to refer enrollees to go out of the plan's network for specialty care if there is no appropriate provider available in the network of covered services.

The substitute requires plans to have a process for selecting a specialist as a primary care provider for individuals who are seriously ill or require continued care by a specialist. It allows women in managed care direct access to OB/GYN care and services and allows them to designate their OB/GYN as their primary care provider. It also allows parents or guardians to designate specialist pediatricians in the plan as the primary care physician for children with special needs. The substitute outlines guidelines for the limited continuation of treatment in situations where a patient's care is disrupted by a change in plan or change in a provider's network status, including pregnancy, terminal illness, or institutionalization. It grants individuals access to emergency care without prior authorization in any situation that a "prudent lay person" regards as an emergency.

The substitute grants access to clinical trials to individuals with serious and life-threatening diseases. It requires plans which use a formulary for prescription medications to develop a process for beneficiaries to access medications that are not on the formulary when medically indicated. It prohibits plans from discriminating against their enrollees on a variety of factors including genetic information, sexual orientation, and disability.

Access to Information

The Dingell substitute requires managed care plans to provide certain information to consumers such as access to uniform, comparable information about health plans, plan policies, and providers. It requires health plans to implement appropriate safeguards to ensure confidentiality, update records in a timely and accurate manner, and allow patients access to their records. While the substitute intends to inform patients that their medical records are kept confidential, it does not address the broad issue of medical record confidentiality. The substitute authorizes an ombudsman program in each state to assist consumers in understanding health insurance options, as well as filing appeals and grievances.

Quality Assurance and Improvement

The Dingell substitute requires plans to establish a quality assurance program to monitor and improve care, especially for at-risk or chronically ill patients. It establishes a private-public advisory board to advise the Secretary of Health and Human Services on the standardized minimum data set and other activities to improve health care quality. The substitute requires plans to have a written, objective process for selecting providers and forbids discrimination against a provider based on its license, location, or patient base. It allows a plan to limit the number and mix of providers as needed to serve enrollees for covered benefits.

Grievance and Appeals

The Dingell substitute requires that plans must maintain an internal grievance process that is expedient and conducted by appropriately credentialed individuals. It also requires an expedited process for special circumstances. The substitute requires the Department of Labor and states to establish an independent external appeals process for health plans under their jurisdictions. It prohibits plans from retaliating against providers who advocate on behalf of their patients or against patients who choose to use the appeal process.

Protecting the Provider-Patient Relationship

The Dingell substitute prohibits the use of "gag clauses" that hinder communication between health care professionals and their patients. It protects providers in these situations from retribution and prohibits plans from providing incentives to providers to limit medially necessary services. The substitute requires providers to receive reasonable notice of termination and allows providers to review any information behind the termination decision and appeal such determinations within the plan. The substitute prohibits arbitrary limits from being placed on covered services. It allows treatment decisions to be made according to generally accepted principles and standards of professional medical practice for medically necessary care. It also allows state law to determine whether a health care beneficiary may bring a state cause of action against health plan administrators who cause harm through their actions. Finally, the substitute protects employers from liability when they are not involved in the decision.

Additional Information: See *Legislative Digest*, Vol. XXVII, #19, Pt. III, July 22, 1998.

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